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ORIGINAL COMMUNICATIONS.

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REPLY TO AN ATTACK ON ECLECTIC MEDICINE BY "JUSTICIA," IN AN ATLANTA DAILY DURING THE SESSION OF THE "NATIONAL."

BY ALEXANDER WILDER, M. D.

My attention has been directed to a communication by "Justicia," purporting to "take exceptions" to your very friendly and flattering notice of eclectic medicine.

The avowal that the writer has failed to discover that the world owes anything to the eclectic practice in the matter of remedies, is certainly bold, and probably true. This does not prove, however, that the world is not thus indebted, but solely and simply that the writer has neither eyes, intelligence, nor justice to see and appreciate the matter. The owl cannot discriminate what is plainest in noonday, nor the common bigoted partisan perceive merit in a person or school to which he is a sworn adversary.

It is not true that eclectics use vegetable remedies only, or that they entirely ignore the remedies furnished by inorganic chemistry. It never was true. The fact is pitiful that a man attacking us finds it necessary to make such a statement for the basis of an attack. He needs to do it anonymously.

To allege that those upon whom eclectics exert influence are "the ignorant masses," is unjust and unmanly. Gentlemen do not talk it; the ward politician and his like are those who thus apply opprobrious epithets. The word "quack" really means only a doser with calomel.

In regard to our associations with savants and scientific men in Europe, we can easily point out the extraordinary endeavors put forth by self-styled regular physicians of this country to prevent credits from being given to eclectics and others for what is justly theirs.

It is true that the eclectic is an American practice. Certainly that is no demerit. It was born of American republicanism, and the "regular" practice was born of European despotism, without a scientific basis, and is only an empiricism. Arbitrary legislation, proscription, exclusiveness, and other methods that despotic countries sanction, are accordingly its favorite weapons.

If eclectics were not found in Europe, it would be because they are Americans. If other physicians are found here, they are here as exotics, alien to the institutions of the country. But the reason why eclectic physicians are not found in Europe is the simple one, that in Europe no such arbitrary exclusiveness exists as is fostered here. A man has but to submit to an examination and he is admitted if he exhibits skill and intelligence. In this country no old-school college will graduate, no old-school medical board will license, an eclectic, however worthy. However, there are eclectics in Europe, and eclectics are held eligible as members of the International Medical Congress.

It is preposterous to assert that the "regular practitioner" alone treats disease upon the basis furnished upon morbid anatomy and pathology. Three-fourths of the "regular practitioners" in this country are grossly ignorant of both; and it is not possible for them to exhibit any system of medication so based. They "guess," and follow the routine, trusting to nature and chance.

It is true that eclectics did not first employ cocaine, nor have we ever pretended otherwise. Ere many years nobody will use it, though it is now a craze. Belladonna or nightshade is older than any medical practice now in existence. It was a "witch-

herb," and used to produce abnormal spiritual conditions. Gelsemium, or jasmine, was co-ordinate in its history with the eclectic practice. It has been little known and hardly ever acknowledged except by eclectics and such homeopaths as were willing to learn from eclectics. But the eclectic catalogue of remedies is a large one, and the articles included in it have been in turn first denounced by the old school as "quack" notions, and afterward pilfered by them as inventions of their own. McDade's formula, now so much cried up, is notoriously a formula from Dr. John King's "American Dispensatory," known and read by eclectics for forty years, and just a little while ago baptized as official. The plagiarisms of the "regular practitioners" from the eclectics without honest acknowledgment, are many. But they malign and slander us as grossly as ever.

If I desired to expose "regular medicine" to popular opprobrium, I would have only to quote its text-books and formularies. The success of that "regular practice" is fitly set forth by one of its most famous exponents,—as not only increasing the number but the morality of diseases in the community. I may resume this discussion.—*Evening Capitol.*

BORACIC ACID.

BY LYMAN WATKINS, M. D.

BORACIC ACID has been known to commerce for over a hundred years, its principal use being in the manufacture of borax. It has been used to a small extent as a remedy for the last fifty years, but recently has come into more general use. Boracic acid is a combination of one atom of borax to three of oxygen; probably the medicinal properties of the drug depend upon the large amount of oxygen which it contains. It is known in the older materia medicas as the sal. sedativus hombergi, and was regarded as sedative and refrigerant. In addition to these, it is now known to possess valuable antiseptic properties. The manner in which it acts upon the blood is not known, except that it "isolates a nucleated red mass from a colorless stroma." Bo-

boracic acid is indicated in inflamed conditions of mucous membranes, attended with profuse secretions and fetor. It is spoken of very highly in the treatment of diphtheria ("Pepper's System of Medicine," Vol. 1, p. 109); a saturated solution is used as a gargle, and it is also administered internally. It is an excellent remedy in the treatment of tonsillitis; it rarely fails to abort, or at least shorten, the attack. The medicine should be used as a gargle, and also some of the gargle swallowed occasionally. Two drams of the acid dissolved in four ounces of water is about the usual strength; gratifying success usually follows the use of this remedy in tonsillitis. In simple conjunctivities from any cause a solution of boracic acid, five grains to the ounce of aqua rosæ, frequently dropped into the eye is usually curative. A five-per-cent solution will do no harm whatever to the delicate structures of the eye. Finely powdered acid has been placed directly in the eye without producing any but good results; therefore it is a good thing to give those who come after "eye water" to use upon themselves or families, because there need be no fear of injury by too frequent use. In catarrhal conditions of the nasal passages attended with profuse fetid discharge, boracic acid may be used first in solution as a cleansing wash, after which the dry acid should be blown into the nasal passages and allowed to remain until it is necessary to go through the cleansing process again, usually morning and evening. This remedy has been given much praise by those specially engaged in the treatment of diseases of the ear. In otorrhœa it has no superior, checking the discharge and removing the disagreeable odor. It may be used in solution, or dusted into the ear dry. It is an excellent remedy in leucorrhœa where there is a profuse whitish, bad-smelling discharge. It is used as an injection by dissolving one ounce of the acid in eight ounces of distilled extract hamamelis. Where there is an inflammatory condition of the vaginal mucous membrane, attended with profuse fetid discharge, boracic acid is the remedy indicated. Lately this agent has come into use in most zymotic diseases. In speaking of its use in a recent article on scarlet fever, J. Lewis Smith, M. D., says: "It is not my intention in this article to call attention to any remedial agent whihc

has not been fully tried, and its efficacy determined ; but from observations made by myself in nearly twenty families in which scarlet fever was prevailing, I am convinced that boracic acid (*acidum boracicum*), an antiseptic recently introduced into our pharmacopœia, deserves trial as a preventative and antidote to scarlet fever as well as diphtheria." He also remarks that in cases where it has been given the attacks were light and unattended by serious sequelæ. I have found boracic acid useful in the treatment of a form of dyspepsia, characterized by a profuse secretion of gastric juices, attended with fetid acid eructations after eating. I have administered ten grains after each meal, to the great comfort and relief of the patient—the remedy mostly acting as an antiseptic and delaying fermentative processes.

ITEMS FROM MY NOTE-BOOK.

BY W. S. CLARK, M. D., TORONTO, CANADA.

On April 29, 1886, I was requested to call and see Mrs. H., aged 55, a widow. On my arrival I found a lady who was sallow, and had the appearance of a person who was suffering pain, as her face looked haggard and care-worn. On inquiry I found she had been confined to her bed for months, suffering with gravel, large pieces of which passed out from the bladder every few hours, as the irritation of bladder and urethra produced a constant desire to micturate.

On examination I found the walls of the bladder thickened, and very tender; walls of vagina tender, also the os-uteri somewhat ulcerated; liver sluggish, bowels constipated, nervous system "unstrung," and the lady discouraged. I located the cause of her trouble in her liver, as the jaundiced condition of the system distinctly showed that organ was materially at fault. I prescribed the following:—

R. F. Ext. Leptandra	℥ iv.
F. Ext. Chionanthus	℥ i.
F. Ext. Hydrangea	℥ ijss.

Sig.—A dessert spoonful four times a day.

I have kept her on this medicine for two months, only substituting at times F. Ext. Eupatorium for the F. Ext. of Leptandra, when the latter article acted too feebly, and I needed a diuretic. The result is that the whole system is about normal, and the gravel has ceased to form, and the irritation is about relieved; and my patient is able to walk around the house with comfort.

I had the bladder washed out with weak borax water, and I used a weak injection of acetate of lead and tannin for the os-uteri, and the ulcer seemed to heal nicely.

CASE No. 2.—Miss C., aged 19 years, called at my office to consult about her "liver complaint." She had jaundice, with all the symptoms of a liver disease, producing a jaundiced condition. My eye rested on the peculiar shape of her nose, and as her speech seemed to be affected, I, on inquiry, found there had been forming in one nostril a polypus, which had been prescribed for by several physicians, some claiming it was a cancer.

On examination I found the lump extended back into the posterior nares, and the size of the polypus was the cause of the bridge of the nose being pressed to one side. As all the previous attempts and the different diagnoses of the case seemed to discourage her, it was with no little persuasion that she submitted to my treatment. I threw in the polypus a strong solution of tannic acid and water, with the hypodermic syringe. When she left my office there was no sign of swelling, neither did she suffer any pain, but before she arrived home (fourteen miles) her face was all swollen and she was suffering excruciating pain. She had a hop poultice applied and in forty-eight hours was relieved; swelling had passed away and the polypus was small and loose. In a few days she worked the dead lump out of her nose, and since I have been trying to get the nose in a normal shape. Her liver trouble is yielding nicely, under the influence of leptandra, chionanthus, and iris versicolor.

THE DEVELOPMENT OF PHYSICAL AND INTELLECTUAL LIFE.

Y H. T. WEBSTER, M. D.

(Continued from June Number.)

THE ARCHEAN AGE.

It is a generally accepted doctrine that matter pervades all space. It is not impossible that even the ethereal blue, through which light and heat penetrate for millions of miles, is pervaded by a material which, concentrated, would become tangible substance. Hydrogen, the lightest of gases known, has been reduced to a liquid state, and finally to solid mass, by the aid of cold and pressure.

Indistinct patches of light in the heavens, consisting, as determined by the spectroscope, of glowing gases, nitrogen and hydrogen—nebulae—have been supposed to represent the condition of our solar system before its planets were formed and hung in their orbits. Though not a demonstrable proposition; the nebular theory presents many plausibilities consistent with established facts.

Laplace advanced the theory that the solar system was once an immense nebulous mass, filling the space at present occupied by the planets, the center of which was the sun; and that this mass had a rotary motion, as some of the nebulae of to-day. As cooling and condensation went on, a gradual contraction of the mass toward its center occurred, and a consequent increase of motion, until the centrifugal force more than counterbalanced the attraction of the center, and a ring was thrown off revolving still along with the inner mass. The contraction still progressing, and consequent increase of motion, there came another period when the centrifugal force asserted its sway, and another ring was separated. This continuing, the central mass was successively lessened by the separation of portions from its circumference; these to become finally independent globular bodies, revolving in their orbits about the central mass, the sun; for, as

cooling went on in the detached rings, they would become liquefied and tend to assume globular forms. Where condensation went on with uniformity, a ring would tend to break up into a great number of small planets, as seems to have been the case between the orbits of Mars and Jupiter. Usually, however, it is supposed that condensation took place more rapidly in some one portion, and that a number of the rings coalesced each into a single planet.

There are a number of cogent reasons for believing this conception to be correct. The planets all move around the sun in the same direction, and all the larger ones have their orbits in the same plane and nearly in a circle. They revolve on their axes in the same direction, and the satellites seem to have been set in motion by the one primary force, as the direction of their motion is the common one.

But, whether there be any truth in this theory or not, there arrived a time in the development of our own planet from which accurate tracings can be made. There is no question that the earth was once a molten mass; for all primary rock bears evidence of igneous action—of having once been in a molten state.

We can imagine the earth, then, as once a monster mass of liquid fire, swinging through its orbit, and revolving on its axis, partially hidden in a pall of vapors and sulphurous smoke which hung about it and hovered on its track, moving onward by the same force which propels it now; while within its vast seething depths were carried on, under an immense pressure and intense heat, those subtle chemical elaborations which prepared the former flame of burning gas for a *terra firma* where life might make its beginning.

‘Prof. Helmholtz,’ says Dana, ‘has calculated, from the cooling of lavas, that the earth in passing from 2,000° to 200° C., must have taken *three hundred and fifty millions* of years. But the temperature when the Archean was ended was probably not over 38° C. (100° Fahr.), to reach which many more scores of millions of years must have been passed. What complex changes the constant heat and pressure of these millions of years

must have impressed upon the elements grouped here. Yearly the great store-house of nature's laboratory is now yielding up the treasures then evolved.

With cooling of the surface came the formation of a crust, and as cooling progressed still further, contraction resulted in unevenness of surface, for the crust, lacking elasticity, would not conform evenly to a smaller sphere. Within the crust, the fires still burned, and pent-up gases sought escape at fissures formed by the shrinking surface. Thus volcanic eruptions laid the foundation for mountain ranges, while the condensing vapors fell into the depressions and covered a large portion of the entire surface with water. The ocean was a first, in all probability, a boiling mass, for as the clouds of steam condensed, they fell upon rock still heated, and ages probably went on with the spectacle presented, could there have been eyes to see, of oceans seething and steaming like monster caldrons beneath changing clouds of shifting vapor. But no eye could have seen this, for organic being could not exist in such an atmosphere. Besides the destructive influence of the heat, the atmosphere was pervaded by gases, for the removal of which a long time was required before animal life could exist within its influence.

The ocean was the womb of organic life. Within its mysterious depths protoplasm, warmth, moisture, and a creative principle conspired to the production of the simplest forms of vegetable growth. But this only could come about after the temperature was much below the boiling point—100° Fahr. is estimated as the temperature at which organic life began to appear.

The character of the first cause remains a mystery. Some there are who believe that the elements combined with such nicety as to bring life about upon purely physical principles—electricity perhaps, being the generating power—that life sprang into being through spontaneous generation—not by chance, but through the operation of fixed, natural laws. The majority of people object to a doctrine which disposes of a supernatural interposition. It is natural for ignorance to find explanation of occult problems in superstitious belief. However, there is nothing inconsisten

in referring the origin of life to a divine Author, but how vastly much more consistent with the attributes of a supreme Creator the proposition of evolution than the pottering operations comprehended by the "special creation" hypothesis.

Attrition of the crust began early. The heated waters washing on the primary bottoms, assisted by the chemical action of various of their soluble contents, separated detritus which, drifting and depositing in favorable localities, formed the nidus for the first layer of super-crust, the strata of which compose the pages of geological record.

From these beds of detritus are formed the Archean rocks, which "are the only universal formation. They extend all over the globe and formed the floor of the ocean and the material of all emerged land when life first began to exist. The thickness which they acquired during the long era, from the time of the first-formed crust, can never be known."

The presence of graphite and calcareous deposits in the later strata of the Archean, suggest the presence of organic life during their formation, but no well-defined fossils have been found to corroborate the proposition. The time was approaching, however, when the ocean would teem with invertebrate life, and it is not improbable that in what are classed as deposits of the closing Archean age are buried the remains of the earliest organic life.

In the scheme of creation, nothing has been done in a hurry. For ages after the foundation of the crust the play of the elements engaged in paving the way to a condition in which it might be possible for life to exist, and when this was possible, the beginning was probably small and insignificant, so far as deposits for future record are concerned. We shall see in the future how further developments enhanced the opportunities for still higher forms of life.

(To be continued.)

SELECTIONS.

ALEXANDER'S OPERATION ("SHORTENING OF THE ROUND LIGAMENTS").*

With a Report upon Fifteen Cases in Bellevue Hospital.

THE remarks indulged in to-night concerning this operation, are based upon the results of my labors in Bellevue Hospital.

I have not had sufficient time to study the latest reports from Great Britain, France, or America—the three countries in which the most attention has been paid to it—so that to-night I simply present the outline of my own work, unbiased by that of others. Those who wish to look more deeply into the subject, I refer to the little book issued by Mr. Alexander, to the article of Mr. Adams, in the *Glasgow Medical Journal*, to an extensive article by M. Doleris, in *Nouvelles Archives d'Obstetrique et de Gynécologie*, No. 1, January, 1886, and to the latest one from Mr. Alexander, in the *British Gynecological Journal*, November, 1885.

The situation, origin, attachment, and function of the round ligaments are sufficiently well known to this audience to spare me the necessity of entering into any anatomical or physiological discussion concerning them. There are two points, however, toward which I should direct your attention; these are, their ability to withstand traction, and the effect of the operation upon them and upon the adjacent structures. These ligaments are considered of so little importance, in the non-pregnant state particularly, that we have been in the habit of regarding them as trivial in all respects, certainly as having little capacity to resist anything like prolonged strain.

The observations upon this point made by my colleague, Professor Williston Wright, are, independent of the experience

*A paper read before the New York Academy of Medicine, June 17, 1886.

gained by the operations, conclusive. I removed the outer two inches of both ligaments in our case, and handed them to Professor Wright, that he might test their strength, by attaching weights to them. This was done, and he reported that one of them broke only when the weight had reached five pounds; the other, at four and three-quarters; the portions tested, remember, being the weakest part of the ligaments, the outer ends. By the time that the break occurred they had become stretched to about twice their normal length, but the stretching did not begin until the weight had reached two and three-quarter pounds with one, and three pounds with the other. If, now, we remember how much less than three pounds any prolapse or retroverted uterus will weigh, it is seen that any part of the ligament is sufficiently strong to answer the objects of the operation. It has been my good fortune to examine and note the position of the uterus, round ligaments, and folds of the broad ligaments, in a case which had been operated upon some ten months before, by actually placing my fingers directly upon these parts. It was a case in which the uterus had been held down by a fibroid tumor upon its posterior aspect. The ligaments had been shortened, and the uterus, with its fibroma, was lifted forward and upward, so that the fundus was in the plane of the superior straight. But relief had not been obtained, and the patient, who at the time of Alexander's operation had refused to have Hegar's operation done (removal of the ovaries), now consented to this latter procedure. This offered me an excellent opportunity to observe how far the uterus had maintained its position, as also the condition of affairs about the broad ligaments. The uterus was found to have remained in the position gained for it in the original operation, and the upper border of the broad ligament was spread out like a web, between the round ligament in front, which was moderately taut, and the line occupied by the tube and the infundibulopelvic ligament behind, which was also taut. There was no thickening or other pathological condition of these structures. This action upon the upper border of the broad ligament, spreading it out, is what one would naturally expect, and is in miniature

what happens, as the uterus, rising in pregnancy, makes taut these same anterior and posterior lines. It was of interest, likewise, to note that the ovaries and tubes were lifted well up, but otherwise were unchanged.

The effect of equal traction upon both of the round ligaments, is to lift the fundus of the uterus forward and upward, which movement is in direct proportion to the amount of traction, until the fundus is placed immediately behind the symphysis pubis, where it will stop. If the traction be made upon one ligament only, the fundus will be drawn to one side and upward, until it rests on the pelvic brim, about at the pectineal eminence. In other words, the uterus will follow traction made upon the round ligaments, until it is drawn to the anterior and upper parts of the pelvis. Thus, if it be desired to lift the entire organ well upward and forward, as in procidentia, one may rely upon its accomplishment through this traction. And if this be so in these extreme cases of displacement, certainly it will answer in simple posterior displacement, with little or no descent, in which we merely wish to make the organ rotate upon its transverse axis, and perhaps lift it to but a slight degree. These assertions can be verified on either the dead or living body, by any competent operator.

I have now and then heard it said that those who have performed the operation upon the cadaver, have found some difficulty in drawing the ligaments out from the inguinal canal. I can readily understand this, as it was my own experience in the first dissection made; but I have never had the least trouble in drawing them out on the live subject. I think the difference can be accounted for by the fact that, in the condition of *rigor mortis* (the condition in which such dissections are usually made), the separation of all tissues is more difficult than in the living subject.

A question which at once presents itself is, What would happen should pregnancy occur? will the uterus be able to rise into the abdominal cavity? This, to me, was the one possible objection to the operation, until one of my own cases became

pregnant, where I have been able to watch the result. The uterus has now completed its sixth month of gestation, and but for a dragging pain along the round ligaments, I have been unable to detect any important deviation from the normal course. The ligaments can be easily felt through the abdominal wall, a rare possibility in pregnancy under other conditions. Mr. Alexander, I believe, has reported several cases that have gone on to term without accident of any kind.

Another question which suggests itself is as to the state of the bladder after the operation. All the cases have been questioned upon this point before leaving the hospital, and some several months after. Each one has told me that they suffered no inconvenience with that organ—being able to retain the water as long as usual.

What I have said as to the behavior of the uterus as a result of traction upon the round ligaments, sufficiently explains the *modus operandi* of the operation in relieving the condition to be specified, and the experiments of Professor Wright answer the question as to the ability of these comparatively slender structures to withstand any strain that they might possibly be called upon to bear.

But the crucial test is the clinical result. A number of cases have already been reported by others, and now I beg leave to add fifteen to the list, comprising, as they do, all the patients upon whom I have performed this operation.

CASE I.—M. Mc——, aged twenty-three. Uterus retroverted, enlarged, and tender. Suffers from menorrhagia. Has made repeated attempts to wear a pessary, but could not bear the pain it caused. Uterus was curetted, and two weeks later an attempt at Alexander's operation was made. At the expiration of three-quarters of an hour one round ligament had been found, shortened, and stitched in place. The shortening of the second was deferred. The patient expressed so much relief that she was allowed to leave the hospital temporarily, but she did not return. The uterus was drawn to one side and lifted forward, so that it was in the position of latero-version. This operation, though

imperfect because of my lack of skill, gave the patient so much relief that she expressed herself as content with the result.

CASE II.—J. G., aged thirty-five. Extreme retroflexion. Cannot wear a pessary. Menstruation irregular and profuse. Bowels constipated, and every movement of them accompanied by pain. Has habitual backache. Operation performed March 16, 1885. Discharged, cured, May 15. Uterus well up and anteverted.

CASE III.—A. M., aged thirty. This is the case of uterine fibroma mentioned above, in which Hegar's operation was subsequently performed. The result of Alexander's operation was to lift and keep the uterus in a position of anteversion, for ten months—in fact up to the date when last seen, which was a year after the original procedure.

CASE IV.—A. R., aged thirty. Uterus retroflexed and left ovary prolapsed. Cannot wear a pessary, because of its pressure on the ovary. Suffers constantly from dragging pains in the lower part of the abdomen and the back. Operation performed April 28, 1885. Discharged, cured, June 10. Uterus anteverted and well up.

CASE V.—E. J., aged thirty. Uterus prolapsed, so that when standing the cervix rests at the ostium vaginæ. It is somewhat enlarged. Suffers from backache and irritability of the bladder. A pessary has been found useless. Operation performed June 17, 1885. Discharged, cured, July 19. A small sinus remains at the site of the left incision. Uterus drawn well up behind the symphysis, the fundus being about on a level with the superior strait.

CASE VI.—A. S., aged thirty-four. Uterus retroverted, large, tender, and soft. Cervix lacerated, but not ulcerated. She has backache, menorrhagia, and profuse uterine leucorrhœa. A pessary has been tried repeatedly; it caused so much pain it could not be worn. The patient suffers a great deal from nervousness and palpitation of the heart. Operation performed September 21, 1885. The incisions did not heal well, profuse suppuration taking place in both. Slow healing by granulation, therefore, was

the result. With this exception she made a good recovery, leaving the hospital with the uterus anteverted and in excellent position, December 7, 1885. She became pregnant about December 17.

CASE VII.—B. C., aged fifty-one. Fourteen years before entering the hospital, prolapse of the uterus occurred as the result of heavy lifting. This has grown steadily worse, until the uterus, at the time of this observation, was entirely without the vulva, the vagina being everted. The uterus, even after the patient had been confined to the bed in the hospital for two weeks, measured four inches. The bladder and rectum participated in the prolapse, and as a result there was much annoyance from frequent and difficult urination and painful defecation. Operation performed October 5, 1885. On November 2 following, the wounds had healed; the uterus was well up behind the symphysis, and measured two and a half inches. On November 16 the vagina was narrowed, and the perineum, which had been torn many years before, was repaired. The patient was discharged early on December 26, cured; the uterus being then in the same position as placed by Alexander's operation, and measuring two and a half inches, as reported above.

CASE VIII.—A. S., aged thirty-eight. Retroversion of the uterus, the organ being bound down by adhesions. Examination showed also tubal disease. Tait's operation was suggested as the surest measure of relief, but it was declined after the pain and tenderness about the uterus had been relieved. Alexander's operation was performed with the hope that we might be able to overcome the traction of the adhesions. The uterus was drawn into the normal position, and the ligaments were stitched to the pubic bone. But in spite of supporting vaginal tampons, the organ lapsed into its former position, so that on leaving the hospital her condition was much the same as it was on admission.

CASE IX.—A. R., aged thirty-five. Uterus retroverted, large, and tender, but movable. Has suffered from the displacement for five or six years. Has been under treatment constantly, but never received benefit. Pessaries could never be worn. Operated upon January 25, 1886, the uterus being easily placed in its

normal position. Discharged, cured, March 25. • Examined June 20. The uterus found in its normal position, and the patient stated that she was perfectly well.

CASE X.—Aged forty-five. Uterus retroflexed and bound down by adhesions. She suffered a good deal from pain in the back, and the uterus was tender. Menstruation was going on as usual. Operated upon January 9, 1886. The general result was much the same as in Case VIII., although some relief from the troublesome symptoms was obtained.

CASE XI.—A. A., aged thirty. Uterus retroverted, enlarged, and tender, and, as with all the cases except VIII. and X., the organ was freely movable. The usual symptoms of an enlarged and retroverted uterus were present. Had been under treatment for eight years, during which time every device had been tried for her relief, but all failed. Operated upon March 22, 1886. The uterus was placed in excellent position. She had some suppuration in both incisions, which, in connection with rather a depraved state of the general system, retarded the recovery, so that when she was discharged from the hospital, May 15, her condition was not as good as was hoped for. The uterus was in excellent position. She was seen again June 20, and then she was better than she had been for years. All the symptoms belonging to the retroversion had disappeared, but a burning pain in the incisions annoyed her a good deal. The uterus was well up and anteverted.

CASE XII.—B. K., aged thirty-eight. Uterus retroflexed, enlarged, and tender. She believes that the displacement resulted from a fall, five years before admission to the hospital. Has suffered from the symptoms of posterior uterine displacement ever since. Has never been able to get relief, although she has been under treatment for several years. Operated upon April 13, 1886. Discharged, cured, May 17, the uterus being in good position, anteverted.

CASE XIII.—M. C., aged twenty-three. Both ovaries prolapsed, slightly enlarged, and tender. The uterus, although sharply anteflexed, is very low in the pelvis. She suffers from

dragging pelvic pain, has menorrhagia and dysmenorrhœa. These symptoms have been present only one year. Treatment outside of the hospital has failed to afford relief. Operated upon April 26, 1886, the uterus and ovaries being lifted up and forward, so that they were well away from the posterior pelvic floor, their former position. Discharged May 26, the uterus and ovaries in the same position as placed by the operation. The troublesome symptoms have disappeared, and she says she is well.

CASE XIV.—K. C., aged twenty-seven. Uterus retroverted, large, tender, but movable. She has suffered for six years from the symptoms of posterior displacement and congestion of the uterus. All treatment has proved unavailing. Operated upon May 28, 1886. Uterus placed in the normal position. The right incision suppurated, otherwise the case did well. June 26: She is now in the hospital, but is doing so well she will be able to leave in a week or ten days.

CASE XV.—A. F., aged forty-five. Prolapse of the uterus for five years. Operated upon June 23, 1886. The uterus was drawn well up to the symphysis. This is the only case in which I have found the round ligaments fragile. Both of them broke with the ordinary traction before I could draw them from the rings. The canals had then to be opened; the ends were again caught, and by very careful traction I succeeded in getting them well out. The age of the patient would scarcely account for the brittleness, for in Cases VII. and X., the first fifty-one years, the second, forty-five, no such condition was found. I can only suggest that possibly it is a condition found in very fat women, for obesity was fully developed in this patient. The ligaments were smaller than in any of the other cases. This patient having been operated upon since my paper was read, too little time has elapsed to make any report upon the result.

A glance at these cases will show that I have applied the operation to all the conditions for which it has been recommended, and to two which have been excluded by the originator of the procedure—the two with adhesions holding the uterus down. The result in these satisfies as to the propriety of excluding all such. So long as the uterus cannot be easily placed in a normal

position by the sound, it stands outside the domain of Alexander's operation. Such cases can only be treated successfully by a plan which I have been driven into, namely, by abdominal section; then tearing up the adhesions, and removing the tubes if they require it, but if they do not, by placing a drainage tube behind the uterus, as we have to do in many ovariectomies, and leaving it in for forty-eight hours. By this method I believe, we secure permanently an anterior position for the organ.

Recapitulating the conditions for which I have performed Alexander's operation, we find them to be: Retroflexions, four cases; retroversions, six cases; retroversions with prolapsed ovary, one case; prolapsed ovaries, one case; prolapse of the uterus, three cases.

In studying the advantages of Alexander's operation, I confess that its application to cases of prolapse of the uterus has interested me most. At the risk, therefore, of wearying you with a side issue, I will speak more particularly of it. Prolapsus uteri is the joint result of rupture of the perineal structure, and stretching of the uterine ligamentous supporters. These supporters are chiefly the utero-sacral and basic lines of the broad ligaments. Its principal perineal support is the pubo-coccygeal division of the levator ani, or, as I think it better named, the pubo-perineal division, *inclosed between its layers of fascia*.

The manner of the destruction of the usefulness of this muscle matters but little; the result sooner or later will be the yielding of that portion of the pelvic floor which it guards, and the descent, first, of the vaginal wall; next, of the uterus.

If it were possible in all cases to restore the normal resistance of the pelvic floor, we might not find it necessary to do more for the prolapse; but, as a matter of fact, this is rarely accomplished, because of the great difficulty of reaching and uniting the torn ends of the pubo-coccygeal muscle and its fasciæ; or the impossibility of correcting the relaxation due to subinvolution or congenital defect.

That the recognized perineal and vaginal operations fail to reach the essential causes of defect in the pelvic floor is proven

by the constant recurrence of prolapse in cases subjected to the most elaborate and thorough operations upon the perineum and vagina. This being so, we must see if aid cannot be obtained from the round ligaments. I am sure that it can be.

It would appear that the prolapse of the uterus is preceded by a backward displacement of it, and there is much reason for believing that if the organ can be kept not only anteverted, but well forward in the pelvis, it will escape the full force of the intra-abdominal pressure and thus avoid prolapse; and again, when prolapse has already taken place, it is natural to suppose that the relaxed ligamentous supports will the more readily regain their normal dimensions and strength if they can be reinforced by some other suspending support. Now by this operation we not only antevert the uterus, but draw it well up and forward, thus giving its ligaments the reinforcement suggested; and if, in addition, we do what is possible toward the restoration of the pelvic floor, we then will have given the case the best, and, to my mind, the most rational treatment yet devised.

The indications for the operations may now be summed up as follows: Prolapse of the uterus; retroversions and retroflexions of the uterus, in which the organ can be placed in the normal position, and yet a pessary cannot be comfortably worn; prolapse of the ovary, the organ being reducible and not large enough or diseased enough to demand removal.

From this statement it will be seen that the operation has a limited but a well-defined application, and that it reaches cases which, without it, we would rather abandon or else subject to graver procedures.

Operation.—I prepare patients for this operation as carefully as I do for an ovariectomy. The bowels are cleaned out both by a cathartic and an enema. The food is mainly fluid for thirty-six hours before the patient is placed on the operating-table. Etherization is a necessity. The first step in the operation proper is the shaving of the mons veneris, and then the *thorough* cleansing not only of that space, but the whole of the abdomen and the upper and inner part of the thighs. The vagina should then be carefully washed out with some disinfecting fluid. The entire

region is then surrounded with carbolized towels. The operator may now stand between the thighs, which are extended, or else take a position to either side. Next, the guide for the incision is to be sought for, and that is the spine of the pubes. This is to be cut down upon, making the incision parallel to Poupart's ligament, and about two inches or more, if necessary, in extent.

The first objective point is the tendon of the external oblique muscles—for in that lies the external inguinal ring. Having reached it, place a finger on the pubic spine, and slide it upward and outward, about half an inch; then the depression of the ring will be felt. Next clear away all the fat and connective tissue which covers the tendon of the oblique muscle about the ring. In this way it is readily exposed. As you watch it now, you will see a mass of fat and vessels, and sometimes the reddish fibers of the round ligament protruding, and rising and falling with the respiratory movements. This mass should now be seized and drawn out; in a moment the round ligament will come into view; then it should be grasped with the forceps and isolated; continuing the traction, it will slide from the ring. If you have mistaken a portion of the tendon of the muscles, you can easily determine the question by running the finger outward along the muscle, for as you make traction you will feel the tendon as a taut line extruding outward above Poupart's ligament. Traction on the round ligament will give no such line. Should you find it necessary to enter the canal in search of the ligament, in view of the important structures which will be approached, the dissection should be carefully made upon a director.

As soon as one ligament has been isolated, the other should be sought for and isolated in the same manner.

The uterus should now be placed in its normal position, unless the case be one of prolapse of the uterus; then it should be pushed as far up and forward as is compatible with safe pressure.

For this purpose I prefer a sound with as large a bulbous end as can be easily passed into the uterus. The sound is a necessity in cases of retroflexion, but the fingers may be substituted in other cases, being placed either in the vagina or rectum as occasion demands.

The ligaments should now be drawn moderately taut, and stitched to the anterior face of the pubic bone, carefully prepared fine silk being used, three to each ligament sufficing. These, having been cut short, the loose ends of the round ligaments should next be cut away. If the ring gapes, or if you have opened the canal, the columns should be carefully stitched together with silk.

If the incisions have been made through a thick layer of fatty tissue, it is best to introduce bone-drainage tubes, closing the wound around them; but otherwise you may close the wound directly, using deep, silk sutures.

Aseptic cotton tampons are then placed in the vagina, and are allowed to remain forty-eight hours. I do not know that they are required, but I think it probable that they relieve the strain upon the round ligaments, and thus aid in their secure attachment in the new position. For a month the patient is kept in bed; after that she is allowed to go about at will; but she should be cautioned to avoid straining efforts, for six months at least.

Coition should be infrequent for a period of two months, dating from the operation; and this is the more imperative if there be tenderness along the line of the ligaments.

With one patient too frequent indulgence led to a good deal of annoying pain along that line. Mr. Alexander advised, after his early operations, that the patients should wear a pessary for two or three months. I have not found this precaution necessary; all of the patients, so far as I know, having been without them from the date of the operation.

Some operators use but one incision, making it just above and parallel to the crest of the pubes, extending to the outside of each pubic spine. I have not tried this path, consequently I am not in a position to speak of its advantages or disadvantages. I find that an impression prevails to the effect that Alexander's operation is both difficult and dangerous; I cannot say that I have found it so. Any competent surgeon who understands his anatomy, and who is familiar with uterine disorders, can readily perform it, and the dangers are trivial provided the operator is *clean*. Abscesses will develop now and then in the incision, but never

if proper precautions are taken, and even when they have occurred with me, no serious result has followed. The question of the development of a cellular inflammation in the broad ligaments, as a consequence of this operation, has also been raised. I can only report that I have had no such result in any of my cases.

Increased experience with the procedure convinces me that it is not a difficult operation, that it is a safe one, and, more than all, that it is a valuable addition to the measures of relief which we have to offer to quite a number of weary sufferers.—*Medical Record*.

A NEW METHOD OF TREATING FISTULA IN ANO.

HAVING paid especial attention to diseases of the pelvic organs, I have frequently been called upon to treat cases of fistula in ano and vagino-rectal fistula.

In my earlier practice, I found great difficulty in successfully treating these cases without resorting to direct operations. The principal resistance to treatment was found in the extreme obduracy of the sanious membrane lining the fistulous canal. It seemed to resist all efforts to bring about healthy granulations.

In my later practice I have adopted, with great success, the plan of treatment, original with myself, which I shall now briefly describe.

This plan of treatment, as I have stated, has been extremely successful, resulting, always, in speedy recoveries, with but little discomfort or inconvenience to the patients. By means of a flexible silver probe, with an eye, I carry a silk thread from the outer opening, through the fistulous canal, into the rectum; then, withdrawing the probe, and fastening to the thread a rubber tube as *large* as can be introduced into the canal, I carefully draw this tube (by means of the thread) through the fistula and out of the rectum, when I secure both ends of the tube together. This part of the

operation being accomplished, there is little more to do than to await the result. The rubber tube will soon set up a *destructive* irritation of the *sanious membrane*; and, in a few days, in place of the characteristic serous secretion from this membrane, there will appear a *healthy purulent* discharge. Then, already, there has begun the disintegration of the membrane.

I allow this first tube to remain a few days longer, when I proceed to replace it with another tube, say one-half the diameter of the tube displaced. The new tube should be introduced by attaching it to the outer end of the tube to be displaced, drawing it through the canal, and fastening its ends together, as directed, with the first tube. In a day or two healthy granulations will be observed (the membrane being obliterated) closing in upon the tube. When this occurs, I again, by the same method, introduce a thin rubber string in place of the second tube. Within another day or two, it will be found that the healthy granulations have closed in upon the string, when, finally, and as a finishing procedure, I replace the string with a fine, flexible silver wire. In a few days this latter may be safely withdrawn; the fine opening will promptly heal, and the fistula be permanently cured.

Almost any fistula, treated by this method, should be cured in from ten to fourteen days, while by ligation the agony is prolonged from four to ten weeks.—*Ernst F. Hofmann, M. D., in Medical World.*

RARE CASE OF A GUN-SHOT WOUND WITH RECOVERY.

PHILLIPE DELBOSQUE, aged 21, while imbibing too freely of a favorite Mexican liquor, "Pulque," at a "Pulqueria," on Sunday afternoon, April 28, attempted to draw his pistol, a 45 cal. S. & W. (secreted under his vest, and between his pants and shirt), and which was accidentally discharged.

He was removed to his home at once, and seen a few moments after the accident. I found that the bullet had entered the hypogastric region of the abdomen, to the right of and above the

bladder, taking a downward and oblique course, and making its exit from the body at the apex of left testicle, producing a slight wound on the inner side of the left thigh, and lodging in his drawers. He had passed his water shortly before my arrival, which was free from blood (the bladder having been quite distended prior to accident). I came to the conclusion, therefore, that the bullet must have passed above and near the neck of the bladder, without injuring that important viscus, under the symphysis pubis and, following the spermatic cord, made its exit as above stated. Hemorrhage was slight, but shock very great; however, as apparently the bladder had not been injured, I gave a favorable prognosis. Fearing subsequent peritoneal trouble, the bowels were ordered to remain at rest, and all purgative interference strictly prohibited. He was given a hypod. of morphia, and cold applications applied to both wounds; liquid diet, and absolute rest enjoined, for fear of secondary hemorrhage.

For the first few days he did exceedingly well, with the exception of suffering some pain, which, however, was easily relieved by hypods. of morphia. On the third day he had some fever, temperature reaching 101 degrees Fahr. (highest point reached).

On the fifth day suppuration commenced from the lower wound, and on the same day pain in testicle and abdomen was excruciating. Scrotum, penis, and left iliac region of abdomen became ecchymosed and remained so until convalescence was well established. Suppuration, especially from the testicular wound, was very profuse, lasting nearly two weeks.

No symptoms of peritonitis manifested themselves, which I attributed in a measure to the quietude of the bowels for the first eight days. He always passes his water freely except when under the influence of morphine. About the eighth day he was greatly annoyed by nausea and gastric irritation, which, however, was easily relieved by an effervescent mixture of pot. bicarb and acid tartaric. When cold applications were no longer necessary, the remainder of the treatment consisted in applying iodoform and zinc ointment alternately over the wounds, which caused them to heal very quickly.

In less than one month my patient was able to ride on horse back and attend to his duties as "*Gendarma*."—*C. K. Gregg, M. D., in Daniel's Medical Journal.*

A CASE OF PERSISTENT SELF-MUTILATION.—A male, aged 25, was admitted on the 18th of November, 1881, suffering from mania, caused by intemperance.

Two and one-half years after admission he exercised the left testicle. The instrument used was the fragment of a wire nail, about half an inch long, which he had somehow obtained and sharpened. With this, whilst in bed at night, he cut through the scrotum, and dissected out the testicle, partly cutting and tearing through the spermatic cord and vessels as high as the external abdominal ring. The explanation he gave of his conduct was that the testicle did not belong to him, but to a black man, in the same ward, and when asked if it hurt him, he replied, "No, but it did the other b—r."

Five months after this, during the night, he removed the remaining testicle, this time using the tongue of a trousers buckle. This operation was much better performed, a clean incision, two inches long, leading into the tunica vaginalis, which remained to line the cavity, the cord being separated close to the testicle. In the former case a large quantity of blood was lost, but at this time there was little or no bleeding. He said he had swallowed the testicle to prevent any one else getting it, and this was probably true, as there was blood about his mouth, and the organ could nowhere be found. He would give no reason for this mutilation, but expressed the opinion that there was no cause for his detention here.

The next injury was the most serious and eventually caused his death. On September 27, 1885, he complained of feeling ill, but careful examination failed to discover any cause for it, though he was pale, looked ill, and refused his food. A small scar on his right temple attracted attention; this, he said, he had made with a nail about two months before, and that part of the nail was there still. When questioned as to how the entrance of the nail was effected, he said he had placed the point against his forehead, had then struck it with his hand until it became

fixed, then, bumping his head against the wall, had driven it quite in. It was then remembered that a small wound, probably that made by the entrance of the nail, was noticed and examined about two months before he became ill, but, owing to the swelling caused by the bumping, it was impossible to detect the presence of the nail, which was not suspected, as he said then that the wound was made by a buckle; and there were no symptoms to lead any one to suspect that the injury was other than a superficial scratch.

A small, hard lump, about the size of a split pea, could be felt under the skin, which had quite healed over it. On cutting down on this it was found to be the head of a wire nail, two inches long, which had been driven through the skull up to its head. Its removal was effected with some difficulty, and a small quantity of pus followed it. There were no head symptoms present, no paralysis of any of the muscles of the body, eyes, of speech, etc., no vomiting, and no special pain complained of. He was quite conscious, and apparently in the same mental state as he had been for some time, and, decidedly, not more demented or stupid. After the removal of the nail no improvement resulted, and he gradually sank, and died next day.—*Australas Medical Journal*.

THE HYGIENE OF OLD AGE.

WITHIN a few weeks the city of Philadelphia has been called upon to mourn the loss of the man who, although very far from intellectually the greatest within her borders, as a citizen was pre-eminently chief. Dying at the age of eighty or eighty-one years, he is universally spoken of as being gathered like a ripened sheaf; yet, within a week of his burial, he was full of mental and physical vigor, and his death at the time was as unnecessary and avoidable as though he had only reached three-score years. A very notable percentage of the deaths of persons who have been successful in life, and have attained beyond the seven-

tieth year, could be, by proper care, long postponed. Failure in life in a large proportion of cases saps vitality, and the man who carries the load of self-knowledge of such failure lives under a persistent strain, whose effects, though usually not recognized, are none the less irresistible. In order to protract an advanced life it is well to understand not only the dangers that beset such a life, but the reason why old age has been attained.

The humorist is greatest when underlying his rollicking is the lesson of a great truth; but perhaps few readers, when they enjoyed the broad fun of the "One-Horse Shay," as portrayed by our inimitable Holmes, have recognized the fact that the man who reaches old age does so largely because he has been constructed upon the principles of the famous vehicle "that ran for a hundred years and a day." Barring accidental deaths from railroad collisions, typhoid fevers, lightning strokes, and other more or less preventable causes, the man who is so built that he is equally strong in all his parts, lives out his appointed days.

Excessive strength in one part is a veritable source of danger. The athlete perishes because his over-developed muscular system perpetually strains and finally wears out a heart or a lung that was originally constructed for a muscular apparatus of half the power of that which he has artificially built up. The larger proportion of mankind die early on account of some local weakness. It ought to be generally recognized that human age is not to be counted by years, and that in some constitutions the general tissues are older at fifty than they are in other individuals at one hundred. Many of the cases of so-called neurasthenia, or nervous exhaustion, of men and women suddenly or gradually breaking down at forty or fifty, ostensibly from overwork, are really cases of premature old age, and are to be nursed and treated precisely as other individuals would be who had reached to four-score years. Moreover, a larger proportion of early deaths are the result of some vital organ being originally endowed with a longevity less than that of the rest of the organism. The reason that consumption is so often utterly irremediable is to be found in the fact that in not a few cases the lung has reached its allotted term of days, and must die because its vitality is exhausted. If

an eye, or other not vital part, fails from lack of vital power, the man exists; but if a lung dies, he perishes.

The result of these lucubrations is to lead us to this point, namely, that the individual who enjoys fair health at seventy-five years of age, has probably been built upon the principle of the "One-Horse Shay," and that he should be treated as a wise man would treat such a venerable instrument of progression. He would certainly keep it off Philadelphia cobble-stones, and allow it only to be bowled along some smooth turnpike, and especially would he avoid all jolts and jars which would throw an unexpected strain upon one part. The principle involved in such case is that which is most vital in the treatment of the old—protection, and especially protection from strain of any one vital part. An old man exposes himself to inclement weather, and especially to a high wind, which suddenly drives the blood from the surface upon the internal organs, and at the same time by its very force checks the enfeebled movements of respiration, which aid in forcing the blood out from those organs. As a result, the man perishes at once, because he has thrown too great a strain upon a weak heart, or, if able to momentarily resist the strain, dies in a few days of pneumonia, due to the congestion of the lung. I have known the sudden shock of good news to strike the old man down as fatally as the pole-ax fells the bullock, by causing the blood to rush with renewed force through the brain, and tear its way through the weakened walls of the blood-vessels. Again, the violent emotion of a sudden bad news may overwhelm a heart which, with care, would have sufficed for its duties for many years. The young athlete in the boat-race pulls at his oar until he drops from heart strain, and, if the heart strain has not been too severe, recovers himself in a few weeks, because the vital elasticity of the heart tissues is in highest vigor. But the enfeebled and brittle heart muscle of the old man, strained in some hurried effort to catch a railroad train, or in some equally unreasonable procedure, has no power of recovery, and rests itself only in death. What is true in regard to the healthy ordinary conditions of the old man is more abundantly true in regard to the diseases of the old. Medicines that perturbate—

measures that bring relief through violent local actions—cannot be borne, and are not to be employed. At the same time, when possible, it is most essential to arrest at once any incipient disorder in the aged. I knew an old doctor, renowned in all lands, who lived ten years beyond the period attained before by any one of his name, largely because, knowing himself thoroughly, every few weeks he arrested in its inception an attack, which, in a few hours, might have gathered fatal force.

I feel some hesitation in attempting to point out in detail the application of the principles which have just been enunciated, lest this paper may fall into the hands of aged persons, and be substituted for a careful consideration of their individual cases by some skillful medical practitioner. Every person, when he advances in years, should go over his whole methods of life and personal habits with some wise counselor, and should adapt his mode of life to the peculiarities of his individual case. With this warning, it is probably safe to briefly point out some of the more important details in the regulation of the life of old people. The first question is in regard to food. The teeth in old age are, of course, lost, and they should, unless under exceptional circumstances, be replaced by artificial teeth, for the thorough chewing of food is even more necessary in the old than in the young, because in the old the digestive powers are apt to fail. With the best artificial teeth mastication is apt to be imperfectly performed; hence the food of the aged should be soft and readily comminuted, and especially should it be of easy digestion. Very few old people need stimulating diet; very many are injured by an excess of nitrogenous food. The kidneys, like all other organs, are feeble, and, if meats and other rich foods are used in excess, they greatly increase the strain upon these organs. Milk and milk products or preparations of breadstuffs cooked with milk, should form a very large proportion of the food of the ordinary aged individual; but individual peculiarities differ so much that personal medical counsel should in all cases be taken, so that the diet may be regulated to the needs of the individual case. Very many old people are hurt by the use of food in excessive quantity; but little exercise can be taken; all growth has ceased, and the bodily fur-

nances which make heat are able to destroy but very little of food fuel. Some little time since I had occasion to lecture on this subject at the Philadelphia Hospital, and an assertion that I then made that most old people are more comfortable, enjoy better health, and probably live longer for the use of wine, has met with very severe disapprobation at the hands of some of the profession whose strong sympathy with the temperance movement dominates their judgment. No valid reasons have, however, so far as my judgment goes, been brought forward to lead me to change my opinion. In the overfed American people the habitual use of wine during youthful or middle age and vigorous health is, we think, an injury rather than a good; but when the powers of life are failing, when digestion is weak, and the multitudinous small ills of feebleness perplex and annoy, one or two glasses of generous wine at dinner aid digestion, quiet for the time being much nervous irritation, and in no way do harm. The sum total of ruin wrought by alcohol in the world is appalling, but it is not lessened by our shutting our eyes to the good that wine properly used may achieve. When in the aged there is a distinct failure of vital power, and especially of digestive power, the call for the habitual use of alcoholic liquors is, in my opinion, imperative. The danger of the formation of any evil habits when a man has crossed the line of seventy is so slight that the most conscientious physician need not hesitate in recommending the daily use of alcoholic beverages to his patient.

It is, perhaps, not universally recognized that in numerous cases of various character death finally is due, in greater or less measure, to cold and to an absolute failure on the part of the body to keep itself warm. In the old the heat-making functions are exceedingly low, and hence it is that few old people are comfortable in a room whose temperature is less than 80°. It is especially important, therefore, that an abundance of clothes be worn by old people; but the very weight of the clothes oppresses, so that it is important that lightness of material should be combined with warmth. There is no ordinary garment which compares in heat-preserving powers with the buckskin jacket, and, in our climate, every man who passes the seventieth year should

furnish himself with such covering. At first the jacket should be only worn when going out-of-doors; but in very advanced age it should form a part of the habitual underwear. The jacket should be high up in the neck and long in the sleeves, and should be of such a length as to thoroughly cover the abdomen. If worn as an under-jacket, it should be perforated so as to allow the escape of the vaporous emanations from the body. Whenever there is any tendency to abdominal weakness, in addition to the jacket and the ordinary warm underclothes, an abdominal flannel bandage should be worn. It ought not to be forgotten that the mass of blood of the human body is in the abdominal organs, and that this is especially so when the circulation is sluggish. It is affirmed by authority that after death all the blood of the body can be put in the relaxed abdominal vessels; hence the importance of maintaining the abdominal warmth, and hence also the good effect in feeble people with pendulous bellies, of the bandage, which helps to sustain the relaxed vessels, and thereby maintain the general circulation. The mechanical effects of tight abdominal bandages are well understood by the profession in the treatment of ascites. It is well known that the sudden removal of the fluid by tapping over the abdominal cavity takes away so much pressure from the abdominal vessels as to cause them to relax, and draw the blood away from the heart and lungs and brain in sufficient quantity to produce fainting. It is to prevent this that the patient about to be tapped is bound up, and the bandage continually tightened as the water flows off. The importance of the habitual abdominal bandage is, perhaps, no less although not as universally recognized.—*H. C. Wood, M. D., in Therapeutic Gazette.*

HAY FEVER.*

HAY fever, or, as it is more properly called, Vaso-Motor Coryza may be determined as a disease characterized by periodical attacks of acute rhinitis, often complicated with asthma. It occurs as the result of a functional derangement of the vaso-motor

*Read before the Society of Physicians and Surgeons, Minneapolis.

centers governing the supply of blood to the nasal mucous membrane, and the presence of some irritant arising outside of or existing within the body.

There have been a great many theories advanced in regard to the ætiology of this disease. In 1876, Dr. Geo. Beard read a paper in which he pointed out the importance of a neurotic element in its production. Dr. Beard, however, was very far out of the track, as he rejected the idea that nasal disease had any connection with it, and stated that hay fever patients were always free from nasal troubles. Nevertheless he started the ball rolling in the right direction, and succeeded in diverting medical thought from the old pollen and bacteria theories into new and fruitful channels. In 1881, Dr. Daley, of Pittsburg, read a paper showing that at least in a proportion of cases there was local disease of the nasal cavities, the removal of which effected a cure of the hay fever. In 1883, Dr. J. N. McKenzie, of Baltimore, read a paper in which he stated that by a course of experiments he had demonstrated the presence of an area in the nostril, irritation of which caused various reflex phenomena. This area was confined to the lower turbinated bone, and the hyperæsthesia was most marked on the posterior portion. He found that irritation of this area by pathological processes or by an extra irritation produced cough, asthma, and various other phenomena. A little later in the same year, Dr. Hack, of Freiberg, discovered a sensitive area in the anterior part of the nose, implicating the region supplied by the nasal nerve; stimulation of this area caused symptoms common in hay fever, such as itching, lachrymation, etc. Dr. Sajous, of Philadelphia, discovered another sensitive area located on the middle of the lower turbinated bone, including filaments of both the nasal and spheno-palatine nerves; irritation of this area produces symptoms of both hay fever and asthma. Thus, when the local disease is limited to the anterior part of the nasal passages, not extending outside of the distribution of the nasal nerve, we have hay fever pure and simple. When it is limited to the posterior portion and confined to the distribution of the spheno-palatine nerve, we have asthma only. When it is situated in the middle portion where terminal fila-

ments of both nerves meet, we have the whole train of symptoms.

This view has been confirmed by the cases which have come under my observation: For example, in one case where I had symptoms of both, I found a posterior hypertrophy of the right inferior turbinated bone, and a spur-like growth on the left side of the septum anteriorly. In another case, where asthmatic symptoms predominated, I found small posterior hypertrophies on both sides, and chronic hyperæmia and sensitive spots in the middle area. In another case, with very little asthma and hay fever symptoms very marked, I found simple chronic rhinitis with sensitive spots anteriorly, involving also the middle area, but no trouble posteriorly. In every case where the nose has been carefully examined, these sensitive spots have been found accompanied by some pathological condition of the mucous membrane; hence it seems pretty certain that local disease in the nasal cavities is an important and necessary factor in its ætiology. The most conclusive proof of all, that certain pathological conditions of the nasal passages are necessary to the production of the affection, is the fact that after the removal of the nasal disease and the reduction of the hypersensitiveness by means of the cautery, a paroxysm cannot be produced. The initial trouble is probably some pathological state which induces an organic change in the terminal nerve filaments, thus causing the hyperæsthesia. The pathological states most frequently met with in the order of their frequency are: simple chronic rhinitis, hypertrophic rhinitis, deviation of the septum and polypoid growths.

Polypoid growths do not cause trouble unless they arise from or impinge upon a sensitive spot. I have never seen the disease present in a case of atrophic rhinitis, nor do I believe it possible for it to occur in these cases. Sometimes there seems to be little or no catarrhal trouble present, and we have nothing but the sensitive spots. In these cases there is probably some latent pathological condition which cannot be detected by ocular inspection, or a chronic hyperæmia may have been present and passed off, leaving the mucous membrane in a state of hyperæsthesia.

I have found these diseased conditions and sensitive spots in a

great many patients, who, of course, were exposed to the contact of irritating substances and yet were never troubled with hay fever. Why should these escape? The answer to this question brings us to consider the second condition necessary to the production of the affection, viz.: A functional derangement of the vaso-motor centers governing the supply of blood to the nasal mucous membrane. This derangement, or predisposition on the part of the individual, may be inherited or acquired. In the majority of cases heredity can be traced. In a smaller number it is probably induced by some previous severe illness which leaves the nervous system in a debilitated condition. For example, in one of my cases I could get no history of heredity, but the patient had had all of the diseases of childhood, besides diphtheria and typhoid fever. Dr. Sajous gives a list of forty cases; fifty-five per cent of these gave evidence of heredity. He also inquired very carefully into the personal history, and found that nearly half of them had had all of the diseases of childhood in which a neurotic element plays an important part. All of them had had whooping-cough, in which the neurotic element is most marked. This would suggest a common systematic cause for both, viz.: a deranged condition of certain nerve centers upon which the contagion or irritant acts with effect.

Again there are a great many substances which are capable of inducing a paroxysm, but they do not affect all individuals alike. There may be only one or more which will affect a certain individual. Those which will affect one may have no effect on another. We know that this power of differentiation does not reside in the terminal nerve filaments but in the nerve centers themselves. Hence there must be some exalted state of the vaso-motor centers, which renders them very susceptible to certain irritants. In cases of some years' standing there are certain premonitory symptoms, such as tickling in the roof of the mouth, pain in the back of the head, chills, etc., occurring from two to twenty days before the attack comes on, and before the irritant is present in the atmosphere. The premonitory symptoms often occur when the patient is out of reach of the irritant, for instance, on the sea or in high altitudes, and they are not followed by a

paroxysm. This would tend to show that the nervous element is present and ready to do its work, but the special irritant is wanting. Periodicity is another element common to certain functional derangements and suggests here a nervous origin. From the foregoing premises I think we are justified in drawing the conclusion that there is a neurotic element concerned in and necessary to its production.

We come now to consider the third and last condition essential to the production of the affection, viz.: The presence of some irritant. The theory that pollen is the exciting cause in the majority of cases is without doubt the true one. In support of this view it has been demonstrated that the application of a very minute quantity of it to the sensitive membrane will produce a paroxysm. The disease occurs during the period of the year when the plants are giving off their pollen. Plants undergo the different stages of their development at the same time each year, thus accounting for the regularity with which hay fever recurs. A hay fever patient will be able to tell you the month, very often the day of the month, and sometimes almost the hour in which the attack will occur. The theory that dust alone, without an admixture of pollen, will cause it is not tenable, when we consider that the disease rarely occurs when plants are not flowering, although the air may be filled with other kinds of dust. Moreover, we can readily see how pollen, on account of its low specific gravity, is diffused over large areas, and becomes mixed with the various kinds of dust in the city as well as in the country. Hence there are but few places free from the presence of it. These are places of high altitude, or remote from the various kinds of vegetation, which give off the special irritant. They are known as hay fever resorts. This also accounts for the freedom from the disease while on the water at a distance from land. Even here the disease has occurred, but it was set up by opening a package of the obnoxious plant in the presence of the sufferer.

There may be several plants which will affect the same patient with varying degrees of intensity. A plant that will affect one patient may have no effect whatever on another. Some patients may be free from the disease in the West who have been great

sufferers in the East. The reason for this may be that they have moved out of the range of growth of the obnoxious plant; or it may be that the change of climate has had a tonic effect on the nerve centers themselves, rendering them less irritable. Besides the pollen of plants, emanations from fruits, animals, some perfumes and powders, such as ipecac, may set up a paroxysm. There are other cases in which the irritant does not come from without but arises within the body. This is undoubtedly due to some reflex irritation acting directly on the nerve centers themselves. In these patients attacks may come on at any time, summer or winter. McKenzie reports a case of this kind. He attributed it to ovarian disease. The attacks were especially severe during the menstrual period. The patient was entirely relieved by removal of the nasal disease, however, showing that this was a necessary element in its production, although the irritant acted on the nerve centers instead of on the sensitive mucous membrane. Attacks have been brought on by walking on a cold surface with the bare feet, the falling of ice-cold water upon the instep, sudden exposure to draft, etc. Dr. McKenzie has reported a case lately which seems to be mainly a manifestation of hysteria, as an attack was brought on by the presence of an artificial rose. Paroxysms could be produced in the patient by a great variety of causes, so that probably in a limited number of cases the psychic element enters largely into the ætiology. As all of these cases have been permanently relieved by treatment directed to the nose, the fact that the irritant may act on the central system instead of on the sensitive membrane is of little importance in the management of the case. It serves simply to explain certain anomalous cases, in which it would seem that the third element, or the presence of an irritant, was not necessary to the production of a paroxysm.

In summing up the ætiology, then, we find these conditions necessary to the production of a paroxysm—first, certain diseased conditions of hyperæsthetic areas in the nasal passages; secondly, a functional derangement of the vaso-motor centers governing the supply of blood to the nasal mucous membrane; thirdly, the presence of some irritant.

We are all more or less familiar with the symptoms of this disease; therefore little need be said about them. The irritation and occlusion of the nasal passages, the paroxysmal sneezing, suffusion of the conjunctiva, frequent cough, and dyspnoea and oppression, form a picture which once seen is not easy to forget.

The pathology of hay fever is the pathology of the existing disease in the nasal passages, together with an organic change in the terminal filaments of the sphenopalatine and nasal nerves, which accounts for the sensitive spots. There is also an irritable condition of the vaso-motor nerve-centers. It may be interesting to trace the mechanism of an attack. The irritant comes in contact with the hypersensitive membrane in a person predisposed to the affection. The impression is carried to the vaso-motor ganglia by the afferent filament of the nasal or sphenopalatine nerve. The vaso-motor centers send this impression back to the vaso-motor nerves of the mucous membrane. This causes first a contraction of the blood-vessels, which corresponds to the dry stage of acute rhinitis. Then follows a dilatation of the blood-vessels. The large venous plexus which covers the turbinated bone becomes distended with blood, often completely closing the nostril. As soon as the mucous membrane covering the septum and turbinated bone meets and pressure is exerted, we have violent sneezing if in the anterior part, and cough and dyspnoea if in the posterior part. If it falls on the middle area, we get the whole train of symptoms.

The posterior area is supplied by branches of the sphenopalatine ganglion, which possesses a sympathetic root derived from the carotid plexus through the vidian nerve. The carotid plexus is in close relation with the pulmonary plexus, hence it is easy to trace the connection of the posterior area with asthmatic symptoms. The anterior area is supplied by the nasal nerve, one of the principal branches of the ophthalmic. This intimate connection of the nasal nerve with the sensory nerve of the eye, will explain the varied symptoms produced here, such as lachrymation, suffusion of the conjunctiva, pruritus, etc. It is also intimately connected with the ciliary ganglion, which accounts for the dilatation of the pupil and photophobia.

Accepting the theory outlined above as the correct one in regard to the ætiology, the treatment becomes obvious. If we can remove one of the three conditions essential to its production, the other two will be powerless in provoking an attack. The only one which can be removed permanently is the local disease in the nasal cavities. If there is simple chronic rhinitis, it is best treated by thorough cleansing followed by the application of astringents. The most efficacious astringents are tannin in powder or in solution, fine salts, and nitrate of silver. If there is turgescence of the turbinated bones, accompanying the rhinitis without true hypertrophy, one or two applications of some escharotic will reduce these very quickly. The most efficient escharotics are nitric acid, chromic acid, and glacial acetic acid. The nitric and acetic acids should be applied with a very fine applicator wrapped with a thin film of cotton. This causes an eschar to form, which contracts and drives the swollen membrane down to its proper size. Chromic acid is best applied by melting some of the crystals on the end of a probe and placing it in contact with the membrane. After applying the part should be washed with an alkaline solution to neutralize any excess of the acid, and thus prevent it from penetrating it too deeply. Puncturing the swollen membrane with the galvano-cautery point is a very efficient method of treatment. There are other methods of treatment recommended, but these have been most satisfactory in my experience and are all that is necessary.

Anterior hypertrophies are best treated by the galvano-cautery. The blade-point electrode should be used. A cylindrical, hard rubber speculum is first introduced and passed up until the hypertrophy is seen through the opening. The electrode, heated to a cherry heat, is passed through the speculum, and a linear incision made in the hypertrophy. If subsequent applications are necessary, they should be made in the same place, so as not to destroy more of the mucous membrane than is absolutely necessary. For septal growths, posteriorly or anteriorly, the cautery is most efficient. For posterior hypertrophies the cold wire snare is probably the best. This is passed through the inferior meatus and looped over the hypertrophy and slowly drawn through the

growth. If the growth should be cut through rapidly, serious hemorrhage would result, therefore this should be done very slowly. Polypoid growths should be snared off and thin pedicels cauterized. Bony outgrowths from and deviation of the bony septum may often be satisfactorily treated with the dental engine furnished with suitable burrs for the removal of the bony obstructions. Deviation of the cartilaginous septum may often be remedied by the judicious use of laminaria tents, or a wooden plug worn for a considerable length of time. Sometimes by the removal of whatever disease may be present, the hyperæsthesia is reduced and the patient requires no further treatment. But very often sensitive spots are left which require further treatment. This is carried out by means of the cautery. This treatment requires a very powerful battery and an electrode made especially for this purpose. I have an extra cell which I attach to the battery I use for ordinary operations. This gives me a very powerful current. The electrode is made with the ordinary sized copper wire, but has a very fine platinum wire for the tip. The object of this is to get a white heat instantly while the electrode is applied to the mucous membrane. The treatment is then carried out in the following manner: The electrode is inserted into the nostril and passed around until a sensitive spot is touched, then, holding the electrode perfectly still, the circuit is closed for an instant only, just long enough to sear but not to destroy the mucous membrane. Then the electrode is passed along to another sensitive spot, and this is treated in the same manner. About three places should be cauterized at one sitting. These should be in the same nostril and as far apart as practicable, in order to lessen the liability to subsequent inflammation. I have never had any trouble with this, and if proper care is taken in making the application, it will seldom occur. In two or three days an application can be made to the other nostril. These should be kept up until a probe can be passed around in any part of the nostril without occasioning any reflex symptoms. The application of the cautery in this manner produces very little pain and very seldom results in inflammation.

The cautery probably produces an organic change in the ter-

minal nerve filaments, thus rendering the mucous membrane less sensitive. The most favorable time for treatment is during the interval, at least six weeks before the expected attacks. You can readily see that it would be difficult to remove a posterior hypertrophy or a polypoid growth when the nasal passages were so very sensitive and blocked up by the swollen mucous membrane. But even after the attack has commenced, the patient can be very much and sometimes entirely relieved by judicious use of the cautery combined with palliative treatment. As a palliative, muriate of cocaine has done excellent service in some cases. In others it has failed entirely. Snuffs containing morphia and acacia are also useful. The internal administration of nerve tonics is often useful. Moderately large doses of belladonna or quinia will often shorten an attack; this is probably due to their action on the vaso-motor centers. I have frequently been asked whether the use of the cautery in this way would not impair the sense of smell. Instead of impairing the sense of smell, it often improves it. If anterior hypertrophies are present, the removal of these will improve olfaction, as it allows freer access of odoriferous particles to the olfactory membrane. The lower or respiratory portion of the nasal passages is the only part implicated, and to this all the treatment is directed.

This treatment has been used with success by several of the most prominent specialists in the country during the last four years. It is no longer an experiment, but an established fact. I saw a number of cases treated while in Philadelphia, and have treated five since I have been here, with very satisfactory results. For want of space I will only report one of these.

W. A. D., age. 26. Has had all of the diseases of childhood. Had diphtheria at five years, typhoid fever at ten years. No history of heredity. Mother died of consumption. Father living and healthy. Has two brothers, both healthy. Has had hay fever for ten years. Always comes on the 20th of August, and usually lasts about three weeks, sometimes until frost comes. Upon examination I found simple chronic rhinitis with sensitive spots anteriorly, implicating the middle area to some extent. He also had a simple chronic pharyngitis. Said he was not troubled

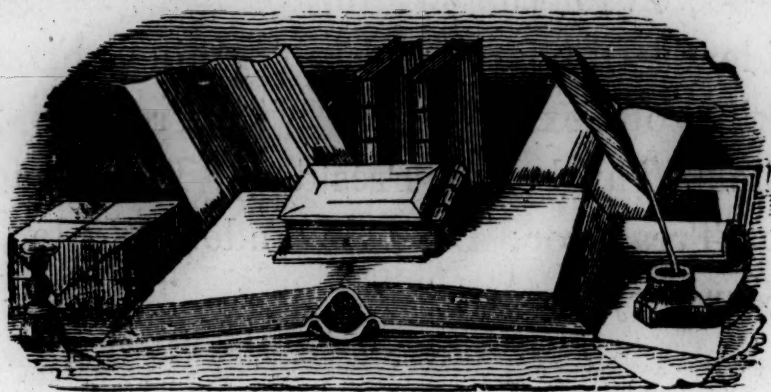
much with asthma during the attack, although there was some dyspnoea. Treated his chronic catarrhal trouble in the usual manner, then cauterized the sensitive spots. Continued treatment until I could pass a probe in any part of the nose without producing any reflex symptoms. Completed the treatment about the first of August. Was entirely free from the trouble this last season.

Four of my cases give a family history of phthisis. There may be no connection between the two, but the fact is suggestive of something of this kind.—*F. S. Muckey, M. D., in Northwestern Lancet.*

"LAME ! lame !" sighed Mrs. Partington. "Here I have been sufferin' the bigamies of death for three mortal weeks. First I was seized with the bleeding phrenology in the hampshire of the brain, which was exceeded by the stoppage of the left ventilator of the heart. This gave inflammation of the left borax, and now I am sick with the chloroform morbus. There is no blessin' like that of health, particularly when you're ill."

WE have received the first number of Vol. I of *Progress*, the new aspirant for honors, published in Louisville, by D. W. Raymond, and edited by Dr. Dudley S. Renolds. Judging from the first number, the editor means business, and has come to remain with us in the journalistic world. May success crown his efforts.

WE are sorry to hear that Dr. F. A. Johnson, for many years a practitioner of Portland, Oregon, died on the 10th day of May at Durkee, Oregon, from abscess of the liver. May he rest in peace, unincumbered with the ills of life that a physician at all times experiences.



EDITORIAL.

The National at Atlanta.—The National Eclectic Medical Association met, agreeable to appointment, and from reports we believe held a series of interesting and successful sessions. One of the old wheel-horses, Professor Howe, was absent, he being at the present time sojourning in Europe; but the cause was well represented by such men as Scudder, Wilder, Jay, Younkin, Goss, Beam, Munn, Stratford, and others.

The press of Atlanta awarded the occasion its full meed of notoriety, and the members were royally treated by the profession of Atlanta.

Valuable papers were presented by various members of the association. Among them was a paper by L. T. Beam, M. D., Johnstown, Pa., on "Organization and Co-operation Our Bulwark of Safety," for a copy of which the author has our thanks.

The notoriety given the eclectics seemed to have displeased some one, who furnished an article for publication in one of the Atlanta dailies, attacking eclectics. We have not the article, but publish a reply which appeared in the same paper, the *Atlanta Evening Capitol*, over the signature of Dr. Alexander Wilder, in another portion of the journal. Professor Wilder has presented some very hard nuts to crack, as the reader will observe on perusal of the article.

Through the courtesy of Drs. A. Wilder and L. T. Beam, we are in possession of a number of Atlanta dailies, which contain notes on the meeting.

The next year's meeting will be held in Waukesha, Wis., and we are resolved that California must be represented.

The officers elected for the ensuing year are Dr. L. E. Russell, of Ohio, President; Dr. Batcheler, of Maine, First Vice-President; Dr. Adkins, of Texas, Second Vice-President; Dr. H. H. Morris, of Illinois, Third Vice-President; Dr. James Anton, of Lebanon, Ohio, Treasurer; Dr. Alexander Wilder, of Newark, New Jersey, Secretary.

The San Francisco Book House.—Those of our readers who need medical books, should remember the address of Wm. S. Duncombe, 211 Post Street, San Francisco. Mr. Duncombe has been in the house of Wm. Wood & Co., of New York, for many years, and is thoroughly conversant with medical literature. He is also a very gentlemanly and obliging person, who puts one at his ease at once, and spares no pains to provide him with what he requires. Our physicians of this coast should call on Mr. Duncombe when in the metropolis, and make his acquaintance for future emergency, even if they do not then need any of his stock in trade.

Ah There! Louisville.—A convention was held at Louisville, May 6, by eclectics and liberal-minded physicians of Louisville, Jeffersonville and New Albany. The meeting was largely attended and much enthusiasm displayed. The result of it all was, the organization of "The Louisville Eclectic Medical Association," with the following officers: President, Dr. T. Timesick; Vice-President, Dr. John Loomis; Secretary, Dr. D. A. Loomis; Treasurer, Dr. P. P. Price. We hail this piece of news with delight, and that the association may live long and prosper is the earnest wish of the CALIFORNIA MEDICAL JOURNAL. M.

They Will Come.—Eastern people who know nothing of the glorious climate, beautiful scenery, together with the genial class of people who compose the population of the Pacific Coast, are constantly desirous to come to the golden West to ascertain for themselves as to what we can boast of. When they once arrive, they are only too well satisfied, and do not wish to return to the country where they are compelled to place themselves in an oven

during the winter months and seek the soothing effects obtainable in an ice-house to prevent that which is mortal from melting in the summer. Another one of our friends has become infatuated with our climate, Henry C. Parke, of the firm of Parke, Davis & Co., Detroit, and has sought and found a location where he can sleep during the winter with nothing more than a blanket over him, instead of three feet of feathers. He has purchased a beautiful orange grove at Pasadena, Los Angeles County, which he can rightly term Marathon, since "the mountains look on Marathon and Marathon looks on the sea."

M.

Who Is to Blame?—A ten months' old babe died in San Francisco recently under such circumstances that the friends and relatives deemed it necessary to have a coroner's inquest, to determine whether the child died of cholera infantum or from the poisonous effects of a medicine placed in a prescription by mistake, by the druggist who filled it.

The child was taken ill, and a physician was sent for, who declared it a case of cholera infantum and prescribed, and used the word "salep," also the abbreviation "spl." The druggist, a young man of about 19 or 20 years of age, took the word "salep" for "jalap," and the abbreviation "spl.," which was intended for "simple," for "sarsaparilla." Upon this showing the coroner's jury found that the child had died of cholera infantum, and censured the druggist for not being more careful in putting up the prescription. This was all well and good, since censure will do no man harm, especially a young man starting out in business; we, however, believe that the jury should not have forgotten the medical gentleman who wrote the recipe. The fact of the jury censuring the young man may materially injure the business of an entirely innocent and deserving gentleman. Our sympathy wholly lies with him, not only because we admire the pluck and enterprise in a young man to start out early in life, and make his mark in the world ere the dial of time proves him to be an old fossil, but also because it requires the services of a Philadelphia lawyer to come even within hailing distance of the truth, or what is intended by the "hieroglyphics" of the majority of phy-

sicians in their prescription writing. Medical gentlemen, knowing that abbreviations are numerous, and also that one may be readily misconstrued, should be ever on the alert, and write them so that mistakes are utterly impossible unless owing to sheer neglect or carelessness upon the part of the druggist. In such a case, the physician will have cleared his skirts of the whole matter, nor will he cause the blame to be placed where it does not rightly belong. A druggist may make a mistake that will not in the least result injuriously to the patient, in fact, be of no consequence in that respect whatever, and yet the physician will wonder why that patient does not improve under his wise, and perhaps specific, treatment, until at last he discovers that his patient has been filling himself up on simple syrup instead of sarsaparilla, as the case may be. Then the unsuspecting druggist gets "Hail Columbia," and perhaps loses the doctor's patronage, when he was in reality not to blame. Physicians perhaps, all over the world, are noted for their very poor penmanship; even here in the Athens of the Pacific we can point out a dozen M. D's. who are entirely bemuddled when you ask them to read a prescription written by themselves after it has grown cold; gazing at it in open-mouthed astonishment, they inquire who the d— fool is who wrote that prescription. Juries should, therefore, be less severe on the druggist, and more so on the physician, and the latter may expect sympathy from us when he learns to write his a b c's so that an ordinary pharmacist can cipher them out. Until then, we are on the other side of the fence.

M.

WE have recently been handed the following nut to crack:—
"A medical school has at its head a man by the name of Hanna. If a whole school of doctors cannot find out what is the matter of Hanna, the conundrum might as well be given up for good." We take it that what is the matter of Hanna, is man, and, on the principle of *similia similibus curantur*, would suggest that man would be the remedy. We would then have Hanna with man suffixed, which would give us Hannaman, or, perhaps, as the followers of the school would prefer, Hahnemann. And that's "what's the matter of Hanna."

BOOK NOTICES.

A TEXT-BOOK OF PRACTICAL MEDICINE, designed for the use of students and practitioners of medicine, by Alfred L. Loomis, M. D., LL.D., Prof. of Pathology and Practical Medicine, in the medicine department of the University of the city of New York, Visiting Physician to Bellevue Hospital, etc. Three editions, with two hundred and eleven illustrations. Published by Wm. Wood & Co., 56 and 58 Lafayette Place, New York, and Wm. S. Duncombe, 211 Post Street, San Francisco.

The fact that within five months after the first publication of this work, a third edition was called, is sufficient mention of the estimate placed upon it by the profession. We believe it to be the most elaborate and concise work on the symptoms, etiology and pathology of that class of diseases included under general practice that we have ever seen in one volume of this size, and we would commend it to those of our readers who desire to possess an old-school text-book on practice, as the one most likely to fill this requirement in a single volume. The treatment compares fairly well with that recommended by other text-books of this class, but is still a little old for the times in many particulars.

DISEASES OF THE CHEST, HEART AND NASAL CAVITIES, by E. Fletcher Ingalls, M. D., lectures on diseases of the chest and physical diagnosis and on laryngology in the Post-graduate Course, Rush Medical College, Chicago, etc., etc. With one hundred and thirty-five illustrations. Published by Wm. Wood & Co., New York, Wm. S. Duncombe, 211 Post Street, San Francisco.

We have recommended this work to our students for a number of terms on account of its clearness of description and conciseness of statement, and we still prefer it to any work on physical diagnosis with which we are acquainted.

REFERENCE HAND-BOOK OF MEDICAL SCIENCES, Vol. 2.

This volume sustains the favorable opinion we had formed of the work, on examination of the first volume. Medical subjects, from catarrh to eye, are considered in its eight hundred and fourteen pages. When the eight volumes of this work will have been completed, it will constitute a library of value to every physician and student. Publishers, Wm. Wood & Co., New York, Wm. S. Duncombe, San Francisco.

"MEMOIR OF AUSTIN FLINT," M. D., LL.D., by A. Jacobi, M. D., president of the New York Academy of Medicine, now lies before us.

A VERY neat little pamphlet has been received by us, on the Chinese problem. It gives, *verbatim*, the speech of Hon. John M. Mitchell, of Oregon, in the Senate of the United States, Wednesday, April 28, 1886.

"THE NEW YORK MEDICAL MONTHLY," a new aspirant for honors in the world of medical literature, edited by J. Leonard Corning, M. D., has made its appearance. It appears to be a worthy exponent of practical medicine and surgery.

INSANITY AND ITS TREATMENT.—Lectures on the treatment, medical and legal, of insane patients, by G. Fielding Blandford, M. D., Oxon., Fellow of the Royal College of Physicians in London, late lecturer on psychological medicine at the School of St. Georges' Hospital, London. Third edition. Together with "Types of Insanity," an illustrated guide in the "Physical Diagnosis of Mental Disease," by Allane McLane Hamilton, M. D., one of the consulting physicians to the Insane Asylum of New York and the Hudson River State Hospital for the Insane, etc. Published by Wm. Wood & Co, 56 and 58 Lafayette Place, New York.

This is the February number of WOOD'S LIBRARY of standard authors. Blandford is an author of ability, and this edition is revised to bring the subject up to the latest light. The house deserves credit for offering such works at the extremely low prices afforded by subscription to this library. The paper, type, and binding are all first class. No such opportunity was ever before offered for obtaining first-class authors on such subjects, at such nominal cost.

HAND-BOOK OF PRACTICAL MEDICINE, by Dr. Herman Eichhorst, professor of special pathology and therapeutics and director of the University Medical Clinic in Zurich.

Vol. 1. Diseases of the circulatory and respiratory apparatus. One hundred and three engravings. The March number of WOOD'S LIBRARY, a work of over four hundred pages, very thoroughly canvassing the subjects named in the title.

A SYNOPSIS OF MORBID URINE, published on card-board. Wm. S. Duncombe, medical publisher, 211 Post Street, San Francisco.

A very convenient chart of reference in examination of the urine. Such a chart hanging on the office wall tends to keep the mind of the physician clear on the subject of urinary analysis.